

Board of Counseling

P.O. Box 30670

Lansing, Michigan 48909

(517) 335-0918

www.michigan.gov/healthlicense

COUNSELING RELICENSURE INSTRUCTIONS

Authority: P.A. 368 of 1978, as amended

This form is for information only.

NOTE: It is your responsibility to have all required documentation sent to the Board of Counseling. Questions regarding your application can be directed to the Michigan Board of Counseling at (517) 335-0918 three weeks after the date you sent the application. Please allow 4-6 weeks processing time. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid.

LICENSED PROFESSIONAL COUNSELOR - RELICENSURE

1. Completed the application and return it to the Board of Counseling with the appropriate fee. A check or money order drawn on a U.S. financial institution and made payable to the STATE OF MICHIGAN must accompany the application. An application accompanied by the appropriate fee is valid for two years. Applications received without a fee will be returned.
 - a. If your license expired within the last 3 years, you must submit a Professional Disclosure Statement (see information on the next page), complete the relicensure application and return it with the appropriate fee.
 - b. If your license expired more than 3 years ago and #3 below does not apply to you, you must take and pass one of the following examinations:

The National Board of Certified Counselors Examination or the Commission on Rehabilitation Counselor Certification (CRCC) Examination. (CRCC 1815 Rohlwing Road, Ste E, Rolling Meadows, IL 60008; telephone (847) 394-2104.) Arrange for the examination agency to forward an official copy of your scores directly to this office.

 1. You must submit your application for relicensure with the appropriate fee.
 2. You must submit a Professional Disclosure Statement (see information on the next page).
2. Send the enclosed Verification of Licensure or Registration form to any other state where you are currently or have ever held a permanent counseling license, the form may be duplicated as needed. As most states charge a fee for this service, you should contact each state board to determine if a fee is required before sending them the form for completion. The verification form must be sent to the Michigan Board directly from the states(s) where you have been licensed.
3. If your license expired more than 3 years ago and you were originally licensed as a counselor based on receipt of a master's or doctoral degree in counseling or student personnel work that was conferred before October 1, 1991 and you had two years of professional experience before October 1, 1993, complete the relicensure application and return it with the appropriate fee. You must also submit an updated Professional Disclosure Statement. You are not required to pass an examination for relicensure.

LIMITED LICENSED PROFESSIONAL COUNSELOR - RELICENSURE

1. Completed the application and return it to the Board of Counseling with the appropriate fee. A check or money order drawn on a U.S. financial institution and made payable to the STATE OF MICHIGAN must accompany the application. An application accompanied by the appropriate fee is valid for two years. Applications received without a fee will be returned.
2. You must submit a Professional Disclosure Statement (see information included in these instructions).
3. Send the enclosed Verification of Licensure or Registration form to any other state where you are currently or have ever held a permanent counseling license, the form may be duplicated as needed. As most states charge a fee for this service, you should contact each state board to determine if a fee is required before sending them the form for completion. The verification form must be sent to the Michigan Board directly from the states(s) where you have been licensed.

PROFESSIONAL DISCLOSURE STATEMENT

Section 18113 of the Michigan Public Health Code, 1978 PA 368, as amended, requires that a licensed counselor furnish a Professional Disclosure Statement to all prospective clients before engaging in counseling services. **A copy of your Professional Disclosure Statement must accompany your application for licensure.**

THE PROFESSIONAL DISCLOSURE STATEMENT YOU DEVELOP AND SUBMIT WITH YOUR APPLICATION MUST CONTAIN ALL OF THE FOLLOWING:

1. Your name, business address, and telephone number.
2. A description of your practice.
3. A description of your education and experience.
4. Your counseling fee schedule. (The fee you charge your clients. If you do not charge a fee, you must specifically state that you do not charge a fee.)
5. The name, address and telephone number of this agency as follows: Michigan Department of Community Health, Complaint and Allegation Division, P.O. Box 30670, Lansing, MI 48909, (517) 373-9196*

***NOTE:** This information is to be provided solely for the use of your clients in the event that they want to file a complaint regarding your services. This address is **NOT** to be used for any other purpose. All other correspondence to the Board should be addressed to the Michigan Board of Counseling, P.O. Box 30670, Lansing, MI 48909.

GENERAL INFORMATION

1. **NAME AND/OR ADDRESS CHANGES:** If your name and/or address changes please notify the Board of Counseling in writing. To change a name or address, you can download the [Data Change/Duplicate License Request Form](#) from our website www.michigan.gov/healthlicense and fax it to (517) 373-2179 or mail the form to Bureau of Health Professions, PO Box 30670, Lansing, MI 48909. Telephone calls are NOT accepted for these changes.
2. **REFUND POLICY:** If you wish to withdraw your application, you may be eligible for a partial refund. You must notify the Board of Counseling in writing to request a refund.

ORIGINAL LICENSES ARE VALID FOR ONE YEAR OR LESS; SUBSEQUENT RENEWALS ARE GOOD FOR A TWO-YEAR PERIOD.

APPLICATION FOR RELICENSURE

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

Type or Print Only

I AM APPLYING FOR THE FOLLOWING:

- ☐ Full License Relicensure - Fee: \$135.00 71-6401-06
- ☐ Limited License Relicensure - Fee: \$100.00 71-6401-06

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

First Name	Middle Name	Last Name
U.S. Social Security Number	Date of Birth	Daytime Telephone Number
Street Address		
City	State	ZIP Code
All Previous Names and/or Birth Name Used (if applicable)		
Has your Michigan counseling license been lapsed more than three years? <input type="checkbox"/> No <input type="checkbox"/> Yes		Michigan Permanent I.D./License Number and Expiration Date

Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation for any Yes answer you check.

1. Have you ever been convicted of a felony?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you been treated for substance abuse in the past 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you had one or more malpractice settlements, awards, or judgments totaling \$200,000 or more in any consecutive 5 year period?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name			
7. Have you ever had a federal or state health professional license revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you? <input type="checkbox"/> Yes <input type="checkbox"/> No			
8. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified? <input type="checkbox"/> Yes <input type="checkbox"/> No			
List each state(s) in which you hold or have ever held a permanent counseling license, the license number, the date issued, and how the license was obtained. DO NOT LIST TEMPORARY LICENSES. You must have each state board verify license directly to this board office. (Attach additional sheets if necessary)			
State	License Number	Date of Issue	How obtained (Endorsement or Examination)

INSTRUCTIONS FOR RELICENSURE AS A FULLY LICENSED PROFESSIONAL COUNSELOR:

If your license expired **WITHIN THE LAST 3 YEARS**, you must submit a Professional Disclosure Statement.

If your license expired **MORE THAN 3 YEARS AGO**, you must do the following:

1. Take and pass one of the following examinations: The National Board for Certified Counselors Examination (see enclosed NBCC form) **or** the Commission on Rehabilitation Counselor Certification (CRCC) Examination. (CRCC, 1815 Rohlwing Road, Suite E, Rolling Meadows, IL 60008; telephone (708) 394-2104.) Arrange for the examination agency to forward an official copy of your scores directly to this office.
2. Submit a Professional Disclosure Statement.

INSTRUCTIONS FOR RELICENSURE AS A LIMITED LICENSED PROFESSIONAL COUNSELOR:

1. Submit a Professional Disclosure Statement.

PROFESSIONAL DISCLOSURE STATEMENT

Section 18113 of the Michigan Public Health Code, 1978 PA 368, as amended, requires that a licensed counselor furnish a Professional Disclosure Statement to all prospective clients before engaging in counseling services. A copy of your Professional Disclosure Statement must accompany your application for licensure. **THE PROFESSIONAL DISCLOSURE STATEMENT YOU DEVELOP AND SUBMIT WITH YOUR APPLICATION MUST CONTAIN ALL OF THE FOLLOWING:**

1. Your name, business address, and telephone number.
2. A description of your practice.
3. A description of your education and experience.
4. Your counseling fee schedule. (The fee you charge your clients. If you do not charge a fee, you must specifically state that you do not charge a fee.)
5. The name, address and telephone number of this agency as follows: Michigan Department of Community Health, Complaint and Allegation Division, P.O. Box 30670, Lansing, MI 48909, (517) 373-9196. *

*NOTE: This information is to be provided solely for the use of your clients in the event that they want to file a complaint regarding your services. This address is NOT to be used for any other purpose. All other correspondence to the Board should be addressed to the Michigan Board of Counseling, P.O. Box 30670, Lansing, MI 48909.

If you use different disclosure statements for different practice locations, you must submit a copy of you disclosure statements for each location. A new disclosure statement must be submitted to this office within 30 days after a change in any of the above required information.

In order for your license to be issued, a professional disclosure statement is required from every applicant, even if you are not currently practicing. **Your license cannot be issued without your disclosure statement(s) on file.**

Name

CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of the pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant	Date
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Michigan Department of Community Health

Michigan Board of Counseling

P.O. Box 30670

Lansing, MI 48909

(517) 335-0918

www.michigan.gov/healthlicense

MICHIGAN LICENSURE EXAMINATION REGISTRATION National Counselor Examination for Licensure and Certification (NCE)

Authority: Public Act 368 of 1978, as amended.
If this form is not completed, certification will not be issued.

Type or Print Only

Last Name		First Name		Middle Name	
Social Security Number		Home Phone ()		Business Phone ()	
Street Address					
City		State		Zip Code	
Check One	Exam Date	Registration Deadline	Exam Location	Site ID	
<input type="checkbox"/>	January 22, 2005	December 3, 2004	Rochester	2204	
<input type="checkbox"/>	April 16, 2005	February 25, 2005	Lansing	2201	
<input type="checkbox"/>	July 16, 2005	May 25, 2005	Lansing	2203	
<input type="checkbox"/>	October 22, 2005	September 2, 2005	Rochester	2212	

ABOUT REGISTRATION

- The cost to register is **\$120**. This examination fee is non-refundable/non-transferable.
- Registration is required. Deadlines are strictly enforced.
- All exam registration materials must be received by the registration deadline (**postmarks do NOT count**).
- You will receive your admission ticket approximately two weeks prior to the exam date.
- Your admission ticket will include information regarding the date and location of the exam.

PLEASE INCLUDE WITH YOUR MATERIALS

- Your completed registration form with signature.
- Your **\$120** examination fee (please make check or money order payable to NBCC).

WHERE TO SEND YOUR REGISTRATION MATERIALS

NBCC
PO BOX 7407
Greensboro, NC 27417-0407

QUESTIONS ABOUT THE EXAMINATION? Tel: (336) 547-0607; fax: (336) 547-0017; E-mail: nbcc@nbcc.org

I understand that I am taking the NCE for the purpose of fulfilling requirements for counseling certification in Michigan. I authorize the NBCC to provide the Michigan Board of Counseling with examination results. Use of the NCE scores for licensure in other states may not occur until licensure is granted in Michigan.

If I am applying to take the examination solely for Michigan licensure, as opposed to certification, I stipulate that (1) I hold a master's degree in counseling or student personnel work; (2) I intend to apply for licensure as a professional counselor in Michigan within two years; and (3) I will not use the examination results for licensure in another state for at least one year following receipt of a passing score.

Signature: _____ Date: _____

Subscribed and sworn to before me this _____ day of _____, _____
(Month) (Year)

Notary Public Signature

My Commission Expires _____

County/State _____

CHARGE ORDER FORM - DO NOT DETACH

Credit Card Type: VISA ☐ Mastercard ☐ American Express ☐

Account Number: _____ Exp. Date: _____

Name on Card: _____ Amount Charged: \$ _____

Signature: _____ Date: _____

Michigan Department of Community Health
Bureau of Health Professions
P.O. Box 30670
Lansing, MI 48909
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VERIFICATION OF LICENSURE OR REGISTRATION IN ANOTHER STATE

Authority: Public Act 368 of 1978, as amended.

PART I: To be completed by the applicant and forwarded to the appropriate State Licensing Board for completion.

Check the profession for which you are requesting verification.		
<input type="checkbox"/> Chiropractic <input type="checkbox"/> Counseling <input type="checkbox"/> Dentistry <input type="checkbox"/> Marriage & Family Therapy <input type="checkbox"/> Medicine	<input type="checkbox"/> Nursing <input type="checkbox"/> Nursing Home Adm. <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Optometry <input type="checkbox"/> Osteopathy	<input type="checkbox"/> Pharmacy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Physician's Assistants <input type="checkbox"/> Podiatry <input type="checkbox"/> Psychology
<input type="checkbox"/> Sanitarians <input type="checkbox"/> Social Work <input type="checkbox"/> Veterinary		
First Name	Middle Name	Last Name
Previous Names Used	Date of Birth	U. S. Social Security Number
State Board	License Number	Date of Issue

The applicant listed above has applied for licensure in Michigan and has indicated licensure in your State. Please complete Part II of this form and return it to the appropriate Michigan Board at the address shown above.

PART II: To be completed by the State Licensing Board.

Type of License:	Original Issue Date	Expiration Date
Basis for Issuance of License:		
<input type="checkbox"/> Examination - Please indicate type of exam (National, Regional, State, etc.) _____		
<input type="checkbox"/> Endorsement - Please indicate name of state _____		
License Status	Has the applicant incurred any formal or informal actions in your State?	
<input type="checkbox"/> Current <input type="checkbox"/> Lapsed <input type="checkbox"/> Inactive	<input type="checkbox"/> No <input type="checkbox"/> Yes - If Yes, Please attach certified copies of any actions.	
Are formal or informal actions pending?	Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended or revoked?	
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	

CERTIFICATION

I hereby verify, to the best of my knowledge, the information above is true to the records of this Board.

Signature

Date

Type or Print Name

(S E A L)

Title

Full Name of Licensing Board